

US Sports Clinics

Field Hockey Clinic:

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- July 20th – 24th, 2015 (M-F)
- Location: Coolidge Park
- 4:30pm to 6:30pm
- Cost =\$80.00/week
- Ages 6 -14
- (equipment is provided for the week – no additional cost)

Lacrosse Clinic:

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- August 10th - 14th, 2015 (M-F)
- Location: Coolidge Park
- 4:30pm to 6:30pm
- Cost =\$80.00/ week
- Ages 6 -14
- (equipment is provided for the week– no additional cost)

Check out the programs at <https://usasportgroup.com>

PARENT'S NAME: _____

CHILD'S NAME: _____

ADDRESS: _____

CITY: _____

PHONE: _____

EMAIL: _____

AGE: _____ BIRTH DATE: ____/____/____

Register and Pay online at <https://usasportgroup.com>

OR

- +Register through the Recreation Department.
- +Payment is due at the time of registration. If you need to arrange a payment plan, please speak directly with the Recreation Director only.
- +Please fill out and sign both sides of this form and return with payment.

Checks are made out to **Fitchburg Recreation Department**

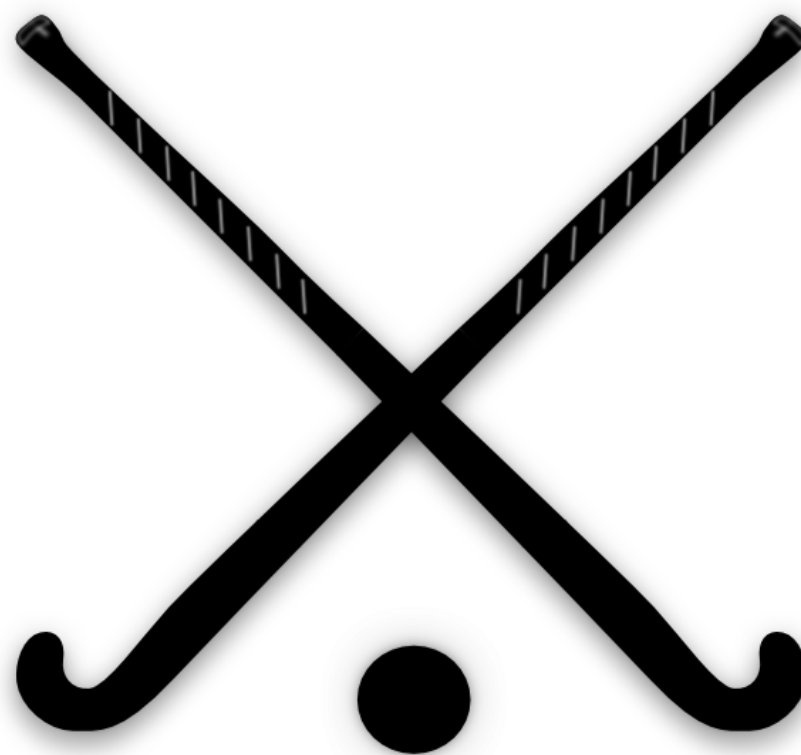
Please mail to:

Fitchburg Recreation Department
301 Broad Street
Fitchburg, MA 01420



If you have any further questions contact the Fitchburg Recreation Department
(978) 829-1815 phone (978) 345-9687 fax

US Sports Programs



Please Register for Field Hockey before June 30th, 2015

Limited number of spots – Sign Up Today

Please Register for Lacrosse before July 30th, 2015

Liability Waiver:

Please accept the named person on this form for participation in the named event. I am aware of the risks inherent with this activity, and release US Sport Institute and the Fitchburg Recreation Department of any and all liability.

I have aware of the risks in the nature of the planned activities and verify that the participant is of sufficient age, ability, and discretion to participate.

I also agree that the participant is at the discretion of the City of Fitchburg Recreation Department; violation of code of conduct could result in removal from the current program without refund.

Parent or Guardian Name (Print) _____

Parent or Guardian Signature _____

Date: _____

FOR OFFICIAL USE ONLY:

Fee: Paid \$ _____

Payment Plan _____

Date: ____/____/2015

Check #: ____/ CASH